



**PA 18-150**—sSB 304  
*Public Health Committee*

**AN ACT ESTABLISHING A MATERNAL MORTALITY REVIEW PROGRAM AND COMMITTEE WITHIN THE DEPARTMENT OF PUBLIC HEALTH**

**SUMMARY:** This act establishes a Maternity Mortality Review Program within the Department of Public Health (DPH) to identify maternal deaths in the state, and review related medical records and other relevant data, including information from death and birth records, the Office of the Chief Medical Examiner’s files, and physician office and hospital records.

It also establishes a Maternal Mortality Review Committee within DPH to conduct comprehensive, multidisciplinary reviews of maternal deaths to identify associated factors and make recommendations to reduce these deaths. Specifically, when meeting, the committee must consult with relevant experts to evaluate DPH’s information and findings from its review of maternal deaths in the state. Within 90 days after meeting, the committee must report its findings and recommendations to the DPH commissioner.

The act establishes related medical records requirements for licensed health care providers, health care facilities, and pharmacies. Under the act, information obtained by the program and the committee generally (1) is confidential and not subject to disclosure, (2) is not admissible as evidence in a court or agency proceeding, and (3) must be used solely for medical or scientific research purposes.

Under the act, a “maternal death” is a death occurring (1) during a woman’s pregnancy or (2) within one year after the date when the woman is no longer pregnant, regardless of whether it is pregnancy-related.

EFFECTIVE DATE: October 1, 2018

**MATERNAL MORTALITY REVIEW COMMITTEE MEMBERSHIP**

Under the act, the Maternal Mortality Review Committee may include the following members, as needed, depending on the case under review:

1. licensed physicians appointed by the Connecticut State Medical Society, including a pediatrician and a specialist in obstetrics and gynecology;
2. a community health worker appointed by the Commission on Equity and Opportunity;
3. a licensed nurse-midwife appointed by the Connecticut Nurses Association;
4. a licensed clinical social worker appointed by the National Association of Social Workers’ Connecticut Chapter;

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5. a licensed psychiatrist appointed by the Connecticut Psychiatric Society;
6. a licensed psychologist appointed by the Connecticut Psychological Association;
7. the Chief Medical Examiner, or his designee;
8. a Connecticut Hospital Association member;
9. a DPH commissioner-appointed representative of a community or regional program or facility that provides services to individuals with psychiatric disabilities or substance use disorders;
10. a representative of the UConn-sponsored Health Disparities Institute; or
11. additional members the co-chairs determine would be beneficial.

Under the act, the committee co-chairs are (1) the DPH commissioner, or his designee, and (2) a representative designated by the Connecticut State Medical Society. The co-chairs must convene a committee meeting at the DPH commissioner's request.

### MEDICAL RECORDS

Under the act, licensed health care providers, health care facilities, and pharmacies must provide the Maternal Mortality Review Program reasonable access to all relevant medical records associated with maternal death cases the program reviews.

The act also authorizes DPH to provide the Maternal Mortality Review Committee with information it deems as necessary for the committee to make recommendations to prevent maternal deaths.